Extragenital Syphilis in Physicians

ERVIN EPSTEIN, M.D., *Oakland*

• *In reply to a questionnaire, 51 cases of extragenital chancres in physicians were reported by 32 contributors. Thirty-five of these lesions occurred on the fingers, six inside the nose, one on an eyelid and one on an arm.*

Otolaryngologists and medical students, interns and residents were affected most commonly.

Examination of patients, deliveries, pelvic examinations, needle punctures and tonsillectomies seemed to be the most dangerous procedures in this regard.

Since such lesions in physicians frequently are diagnosed as pyogenic or malignant lesions and so treated, the importance of a high index of suspicion for syphilis is stressed.

THEORETICALLY, contracting syphilis by other than venereal means should be rare indeed. However, when a questionnaire seeking material for a report on professional dermatoses[1] was sent to a number of dermatologists, 16 of the 60 who answered reported having observed a total of 27 cases of extragenital primary syphilitic lesions in physicians.

Because of the interest expressed in this particular item of the report when it was published, the subject was pursued further by sending questionnaires to another group of dermatologists. Sixty-five more answers were received.

Of the 125 dermatologists who answered the first or second questionnaires, 32 reported observing a total of 51 cases of extragenital chancres in physicians. In many instances, the information given was so sketchy that it was impossible to establish significant statistical data.

In 35 instances the lesions occurred on the fingers, in six inside the nose, in one on an eyelid, and in one on an arm. It may be surmised that the rather high proportion of lesions in the nose occurred as a result of a patient's coughing sputum containing the organism in the direction of the physician. One of the physicians who answered the questionnaire felt that such localization might result from picking the nose with the finger.

The contagiousness of mucosal lesions was indicated by the fact that otolaryngologists were affected more commonly than any other well defined group; six of the infected physicians were in that specialty. Six cases were observed in interns, residents and medical students, five in general practitioners, and two in pathologists.

Surprisingly, routine clinical examination of patients was the most common means of infection (seven cases). In five cases infection was acquired in delivery or in pelvic examination. Three cases were attributed to needle wounds and three to tonsillectomy. Apparently two resulted from autopsy examination and one from exposure in surgical treatment. Except in the cases of the needle punctures, the statement "not wearing gloves" recurred through the reports.

From the Department of Dermatology, Mount Zion Hospital, San Francisco.

DISCUSSION

Almost any physician must have recognized at one time or another the wide range of attitude among his colleagues as to the possibility of becoming infected with syphilis in the practice of medicine. Some have wholesome fear or morbid dread that they themselves might innocently contract the disease from a patient; many have an almost scoffing attitude toward supposition that any of their fellows might so become infected. Usually a physician who sticks himself with a needle used on a syphilitic patient will worry considerably about the possibility of infection. It is difficult indeed to soothe and reassure the "exposed practitioner." The most extreme example of syphilophobia known to the author is that of an intern who, upon learning that he was examining a patient with a positive reaction in serologic test, rushed out of the room, scrubbed and showered furiously, and put all his clothing in an autoclave. The result: bizarre raiment, a rather extraordinary plastic fountain pen that had been left in a pocket, and a somewhat rueful—though healthy—intern.

At the other end of the scale was a syphilologist who confirmed a diagnosis of syphilis by darkfield examination of material from a lesion on the penis of a patient. The patient paid the fee in silver coins and left the office. After pointing out to a preceptee that the coins were undoubtedly teeming with Tre-

ponema pallidum, the specialist pocketed the money, advising the gaping student that one ought not let superstition interfere with one's livelihood.

Of a kindred order are physicians who, upon noting an extragenital chancre in themselves, may mistake it for pyoderma, forgetting previous exposure to syphilis, and consult a surgeon. The surgeon's index of suspicion of syphilis may approach zero, and antibiotic and chemotherapeutic agents may be administered without a diagnosis. The lesion then may heal, but since the amount of the drug given in such circumstances is subcurative, later complications remind the physician-patient of the seemingly "pyogenic" lesion.

Another fairly common mistake is the diagnosis of malignant disease and amputation of a digit or a hand. Unfortunately, the diagnosis of malignant change may be "confirmed" by histologic examination of a biopsy specimen. Surprisingly, this sequence was not unusual in the reported cases.

Undoubtedly, the incidence of professionally acquired syphilis in physicians is low, owing to decreased incidence of the disease, use of rubber gloves and aseptic technique. However, the report of 51 cases of extragenital primary syphilitic lesions in physicians indicates that a real danger exists. Although it is well to reassure exposed colleagues, it is an error to overlook the possibility that syphilis can be acquired innocently from patients.

447 Twenty-ninth Street.

REFERENCE

1. Epstein, E.: Occupational dermatoses in physicians, J.A.M.A., 147:1751-1754, Dec. 29, 1951.

VA Economies in Medical Fields

Veterans Administrator Carl R. Gray, Jr., reporting on his four years as head of the organization, listed economies of $137 millions, with approximately $40 millions saved in medical fields. His summary was presented to the House Veterans Affairs Committee. Savings in the medical department (other than in construction and administration) were said to include:

1. Reduction and control of number of physical reexaminations for adjudicatory action—$25,250,000 saved.

2. Standardization of procedure for collection of fees from insurance companies for hospitalization of veterans with non-service connected conditions—$7,200,000, "which would not otherwise have been paid the government by the insurance companies."

3. Inventory and personnel economies in pharmaceuticals—at least $2 million.

4. VA's operation of its own blood bank program—$3 million saved.

5. VA's operation of its own dental laboratories—$2.3 million saved.

The above economies do not represent reductions in overall spending. VA's total budget for fiscal 1948 was $6,922,457,320, with the medical department getting $588,561,819. For fiscal 1952 the total estimated budget was $4,409,265,220, with $703,190,160 for medical activities.

—Reprinted from *Capitol Clinic*